In the Inner London North Coroners Court

Inquest touching the death of Dr Rosemary Simpson

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Director of Culture and Environment, London Borough of Camden**
1	**CORONER** I am Selena Lynch assistant coroner, for the coroner area of Inner North London
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** I concluded an inquest into the death of Dr. Rosemary Anne Simpson on 28th March 2014. The conclusion of the inquest was "road traffic collision".
4	**CIRCUMSTANCES OF THE DEATH** At about 5.20 pm on 14 January 2014 a double decker bus pulled away from a bus stop outside the Grafton Hotel in Tottenham Court Road. It was necessary for the bus to move over to the right, across three lanes, so that it was at an angle when it came to a stop between the stop line and the studs of a pedestrian crossing. As the lights changed to flashing amber Dr. Simpson crossed the road from west to east, at a running pace. The bus driver did not see her and moved off. Dr Simpson was struck by the front near side of the bus and fell to the ground. She died from her injuries on 28th January 2012.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – [BRIEF SUMMARY OF MATTERS OF CONCERN] The area is often very busy with pedestrian and vehicular traffic and pedestrians frequently cross on the flashing lights, sometimes at speed. Visibility for buses can be affected by the siting of the bus stop, so that some routes have to cross three lanes in a short distance. It is not possible to move the bus stop at the present time.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. It has been suggested by accident investigators that countdown markers and pedestrian sensors would improve safety and prevent future

	collisions.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 24th May 2014. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the family of the deceased and to the representative for the driver of the bus. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**28th March 2014** **Selena Lynch**